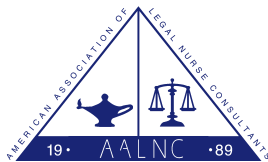


The Journal of
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Consulting**

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The Journal of Legal Nurse Consulting

Purpose

The purpose of the journal is to promote legal nurse consulting within the medical-legal community; to provide both novice and experienced legal nurse consultants (LNCs) with a quality professional publication; and to teach and inform LNCs about clinical practice, current legal issues, and professional development.

Manuscript Submission

The journal accepts original articles, case studies, letters, and research. Query letters are welcomed but not required. Material must be original and never published before. A manuscript should be submitted with the understanding that it is not being sent to any other journal simultaneously. Manuscripts should be addressed to JLNC@aalnc.org or call 877/402-2562.

Manuscript Review Process

Submissions are peer reviewed by eminent professional LNCs with diverse professional backgrounds. Manuscript assistance can be provided upon request to the editor. Acceptance is based on the quality of the material and its importance to the audience.

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Meeting Your Growing Needs

Lynda Kopishke, MSN RN CLCP LNCC



As I look back over my first year as editor of *The Journal of Legal Nurse Consulting*, I am astounded with the talent and willing volunteers that add so much to the specialty. I have had the privilege of working with an editorial board whose dedication and generous gift of time craft this publication. As I review the year-end index of articles, I am awed by the expert information so willingly shared by authors. I feel proud of this printed media and the voice it provides for legal nurse consultants. I take this opportunity to thank both the editorial board and the authors for their support and contributions.

On the east coast, we are experiencing fall, a time when the leaves change color, individuals refocus their efforts after a summer break, and a time of preparation for the coming winter. As editor it is during this time that I begin planning for the next year's *JLNC*.

One of the goals for the American Association of Legal Nurse Consultants is to begin the process of expanding the journal to make it even more useful for legal nurse consultants, attorneys, and those interested in our specialty area of nursing. To begin this process, I seek your input. As readers, I ask that you consider how you use this publication, what additions you would like to see in content and that you contribute your ideas for growing the *JLNC*. I welcome suggestions for potential authors, new ideas for recurring columns, and seek an understanding of the expanding practice settings of our readership.

Legal nurse consulting is growing in momentum and magnitude. Several career guides list legal nurse consulting as one of the top 10 careers for nurses in the next decade. Continuing to be the leading voice for legal nurse consultants takes putting our collective brains together to structure and define the *JLNC* to meet your growing needs for cutting edge information.

Please consider contributing to this effort by sharing your thoughts and dreams for the next decade of legal nurse consulting. E-mail your ideas to me at Advmedconcepts@aol.com. In the January issue I'll share your ideas and update you on the coming year's editorial agenda.

Sincerely,

A handwritten signature in cursive script that reads "Lynda Kopishke".

Lynda Kopishke

Special Thanks

A special thank you goes to my fellow editorial board in the Pittsburgh Chapter: Jane Collins, RN, BSN, JD; Sondra Fandray, BS, RN; Nursine S. Jackson, MSN, RN; and Lori Klingman, MSN, RN for allowing the *JLNC* to reprint "Defending Negligent Credentialing Claim" and "Navigating Ophthalmology Records" in the July 2003 issue.

Additional special thanks for the Detroit chapter of AALNC who support our Question and Answer column on a regular basis. It is the mark of a true professional when knowledge is shared for the betterment of others, so thanks to each of you!

Liability Issues of Informed Consent: Healthcare Provider-Patient Relationship

Eileen Croke, EDD, MSN, RN, ANP

KEY WORDS

Informed Consent, Standards of Disclosure, Reasonable Patient Standard, Health Illiteracy

In today's healthcare system informed decision making is a fundamental patient right. The intent of this article is to provide the legal nurse consultant with information on the informed consent process. This information may be used by the LNC to evaluate medical records and associated documents for lack of informed consent related injury.

Informed Consent Process

In today's health care delivery system, informed decision-making is a fundamental right of patient autonomy. The doctrine of informed consent is based upon the fundamental right of self-determination and the fiduciary nature of the healthcare provider-patient relationship. In legal liability involving informed consent, the focus inevitably seems to fall upon the recorded documentation between the healthcare provider and patient — the substance of which may be translated “directly into the quality of trial evidence, which, in turn, often determines a trial's outcome” (Mawn, 1999, p. 3).

The intent of this educational article is to provide the legal nurse consultant (LNC) with information on the informed consent process. This information may be used by the LNC when evaluating a negligence case for merit which alleges a breach in the standard of care for informed consent. Included are doctrines of consent and informed consent; elements of informed consent; disclosure standards of informed consent; who can give consent; types of consent forms; and accountability for obtaining informed consent. The article introduces guidelines that the LNC can use to evaluate a medical record and associated documents for lack of informed consent related injury.

Doctrines of Consent and Informed Consent

Under traditional tort law, a healthcare provider who performed medical treatments or procedures beyond the scope of a patient's consent was sued under intentional tort theory (battery). In 1914, Justice Cardozo cited the reason for consent in protecting patient autonomy — “Every human being of adult years and sound mind has a right to determine what shall be done with his own body, and a surgeon who performs an operation without his patient's consent commits an assault for which he is liable in damages” (*Schloendorff v. Society of New York Hospitals*, 1914, p. 93). Consent is not contingent on a request for clarification of information by the patient but on a person's right to control what is done to his or her body — and on the prevention of battery (Guido, 2001). Consent may be given in various forms: written, verbal, or implied by a patient's action. To the extent required by state law or institutional bylaws, written consent must be obtained.

The doctrine of informed consent stems from negligence law; although a patient may have consented to a medical treatment or procedure (bare bones consent), the patient may not have received enough information to make a “valid and truly informed choice” (Croke, 2002). Informed consent became a judicial issue in 1957, *Salgo v. LeLan Stanford, Jr. University Board of Trustees*. In this landmark case, the California court system found a physician negligent for failing to explain potential risks of an aortography to a patient who subsequently became paralyzed. A modern approach in tort law views the failure of the healthcare provider to provide a patient with informed consent as a form of medical malpractice based on negligence (Mawn, 1999).

In 1980, the doctrine of informed consent was expanded with a corollary called informed refusal (*Truman v. Thomas*, 1980). Under the doctrine of informed refusal, a health care provider may be held liable for failing to inform a patient of the risks of not consenting to a treatment or procedure (Guido, 2001). There are exceptions, recognized by the courts, to the need for informed consent in situations in which consent is still required. These exceptions (defenses to informed consent) include emergency situations, therapeutic privilege, patient waiver, prior patient knowledge, incompetence of the patient and patient's right to refuse the treatment or procedure (Guido).

Elements of Informed Consent

“Informed consent requires that the healthcare provider meet certain elements before the acknowledgment by the patient is considered informed consent” (O'Keefe, 2001, p. 201). The elements include:

- Patient's diagnosis or clinical impression
- Nature and purpose of the proposed treatment or procedure
- Expected outcomes or benefits
- Complications, risks, or side effects of the proposed treatment or procedure (including death, if it is a realistic outcome)
- Reasonable alternatives (risks v. benefits)
- Prognosis if treatment or procedure is not performed

- Name and qualifications of the individual(s) who will perform the treatment or procedure
- Explanation that the patient can refuse the treatment or procedure without having alternative care or support discontinued (Guido, 2001)
- Explanation that the patient can still refuse, even after the treatment or procedure has begun (exceptions exist — such as, if stopping the procedure may place the patient's life in jeopardy) (Guido, 2001)

Disclosure Standards of Informed Consent

Healthcare providers must be familiar with their state disclosure laws (community standards) on informed consent, as they vary from jurisdiction to jurisdiction. Courts view standards of disclosure for informed consent in various ways — from the perspective of the healthcare provider or the patient — or through medical disclosure laws. The reasonable medical practitioner standard requires that the healthcare provider disclose needed facts to the patient which a reasonable medical practitioner in the same or similar circumstance would have disclosed (*Karp v. Cooley*, 1974). This standard is based on the prevailing medical thought and community standard and the issue is presented at court through expert testimony. Some states which have adopted the reasonable medical practitioner standard include: North Carolina, Florida, New York, and Virginia. Courts in these states view lack of informed consent cases similarly to medical malpractice lawsuits (Mawn, 1999).

The reasonable patient standard incorporates two different tests, the objective patient standard and the subjective patient standard. The objective patient standard is based on “disclosure of risks and benefits as determined by the needs of what a prudent person in the given patient's position would deem material” (Guido, 2001, p. 132).

Materiality is defined as the risk(s) that may affect a patient's decision (*Canterbury v. Spence*, 1972) and is built upon the following question: Would a patient consent to a treatment or procedure knowing (1) the existence, nature, and likelihood of occurrence of a risk and (2) the probability of that type of harm is a risk which a reasonable patient would consider (1993) (cited in Guido, 2001, p. 132).

The second test is the subjective patient standard which requires full disclosure of what the individual patient would deem necessary to make an informed choice rather than what a reasonable person would have wanted to know. At trial, a fact finder (juror or judge) must determine what risks were or were not material to an individual's decision in relation to the treatment or procedure accepted or refused (Guido, 2001).

In *Cobbs v. Grant* (1972) the court ruled, under the reasonable patient standard, expert testimony is not required at trial — a non-medical fact finder can interpret the risks against “fears and hopes” of a patient. Some states which have adopted the reasonable patient standard include: Maryland, Massachusetts, California, Ohio,

Washington, New Jersey, Pennsylvania, and Delaware (Mawn, 1999).

Medical disclosure laws have been statutorily developed in some states. These laws mandate what information (risks and consequences) must be printed on consent forms and disclosed to patients prior to undergoing any treatment or procedure.

Disclosure panels have been developed in Hawaii, Louisiana, and Texas. Composed of professional peers, these panels establish “what is appropriate information” about a certain treatment or procedure that needs to be disclosed to a patient (Mawn, 1999).

Healthcare providers need to know what their state disclosure laws are as they vary from jurisdiction to jurisdiction. For example, California State law on informed consent mandates that if there is a risk of death or serious bodily harm involved, the question of community standard (custom and practice) is irrelevant. Full disclosure is then mandated under the law even if it is not required by community standard (Gargaro, 1999). Courts favor more disclosure than less.

Who Can Give Consent?

Healthcare providers must be knowledgeable of their state laws relative to who can consent to a proposed medical treatment or procedure. Most states recognize that the person consenting must be an adult (age 18), be competent, and voluntarily consent to the proposed treatment or procedure. There are issues of concern for the healthcare provider when obtaining a patient's informed consent. These issues include incompetent adults and minors.

A patient who is “incompetent” is incapable of consenting to a proposed medical treatment or procedure. Examples of incompetent adults include: an individual who has been declared mentally incompetent by the court, is under the influence of drugs or alcohol, or is unconscious. If an individual has been declared incompetent by the court, a court-appointed guardian (either temporarily or permanently) has the legal authority to give consent for the proposed treatment or procedure. If the patient has a written durable power of attorney, the named agent has the decision-making power for the incompetent adult. If a patient has not been declared incompetent by the court, family laws in some states allow a family member to make decisions for the incompetent patient. The order of family selection is the spouse, adult children or grandchildren, parents, grandparents, adult brothers or sisters, or adult nieces or nephews (Guido, 2001). If a healthcare provider believes a patient to be incompetent, the policies of the institution and state laws will specify who is authorized to give consent for the patient and what steps the healthcare provider must follow to ensure legal consent (O'Keefe, 2001).

In most states, minors (under age 18) are not allowed to give consent for a proposed medical treatment or procedure. The legal trend is moving away from parental consent

as the sole consent process for allowing medical treatment or procedures for a minor. Some states allow the minor to consent to selected medical treatments or procedures without obtaining parental consent. These selected treatments or procedures include: diagnosis and treatment of sexually transmitted diseases (infectious, contagious, or communicable disease); medical care during pregnancy; obtaining birth control devices; diagnosis, treatment, and counseling for drug dependency, addiction or any condition relating to drug usage; or treatment for physical abuse (Guido, 2001; O'Keefe, 2001). Other exceptions to the requirement of parental consent include:

- Emergency doctrine is applicable
- Emancipated minor, mature minor, or statutory age of consent
- Court order to proceed with proposed treatment or procedure
- In loco parentis (person or state to stand in for parents)
- Law recognizes the minor as possessing the ability to consent to the proposed treatment or procedure (Guido, 2001)

The laws concerning minors and their ability to consent is fluid and constantly changing. It is the responsibility of the healthcare provider to ensure that the individual giving consent is legally capable of providing the consent as well as ensuring that the law supports the decision made concerning a minor's informed consent (O'Keefe, 2001).

Types of Consent Forms

In liability cases alleging negligence and/or lack of informed consent, the consent form itself may not have legal significance; it may serve only an evidentiary function citing that the healthcare provider discussed the subject matter described on the consent form. In healthcare, there are two basic types of consent forms: blanket and specific. The blanket consent form is a required document the patient signs on admission to the institution and allows for "routine and customary care." Specific consent forms are mandated for invasive treatments or procedures. Information on the "standard specific" consent form includes information such as: the name and description of the proposed treatment or procedure; a section documenting that the patient who signed the form received information pertaining to the clinical diagnosis, risks, benefits of the proposed treatment or procedure, and had all questions answered. The "detailed specific" consent form, designed by statutory medical disclosure panels, includes information on the procedure, risks, alternatives, and consequences printed on the face of the consent form (Guido, 2001).

A research study investigated the use of a universal consent form for enhancing the informed consent process (comprehension and authorization) for eight intensive care unit (ICU) medical invasive procedures. The study sample included 270 medical ICU patients at the University of Chicago Hospital and was conducted between November

2001–December 31, 2001 (baseline period) and March 1, 2002–April 30, 2002 (intervention period). A three-part intervention tool, developed by the researchers, was used for data collection. Part One was a universal consent which allowed the patient or legal agent to give advanced permission for eight commonly invasive procedures in the ICU; Part Two included a description and known complications of the procedure; and Part Three provided information about the universal consent form for healthcare providers.

The tool was distributed to the patient and/or legal agent on admission to the ICU. Results indicated that during the baseline period, 53% of the invasive procedures were performed after authorized consent and compliance increased to 90% during the intervention period. High levels of comprehension by the consenters of the indications for and risks of the invasive procedures were reported for each period (*Managed Care Weekly Digest*, 2003).

It is well purported in the literature that patients will sign anything given to them whether or not they comprehend the information written on the document. Health illiteracy and readability levels were identified in the medical and legal literature as potential liability issues affecting consent forms. In the United States, the number of functionally illiterate adults is increasing by 2.25 million each year according to the 1992 National Adult Literacy Survey (Sweet, 1996). The American Medical Association (AMA) (2002) defines "health illiteracy" as the inability of a patient to read, comprehend, or follow medical instruction/advice. Eisenstaedt, Glanz, Smith, & Derstine (1993) investigated readability levels of hospital blood transfusion consent forms. Results indicated that the average grade level required to understand the consent forms is 14.6 years. Hopper, et al. (1998) investigated readability levels of hospital surgical consent forms. Results indicated that the average grade level to understand the forms is 12.6 years.

The informed consent process includes educating the patient, not just having him or her sign a consent form. In *Grabowski v. Quigley* (1996), the Superior Court of Pennsylvania held that a patient can sue a healthcare provider (medical physician) who fails to explain to a patient what is going on and delegates to a nurse the responsibility of obtaining the patient's signature on an ambiguous surgical consent form that the patient does not comprehend. In *Cromarty v. Hammoud* (2000), the Supreme Court of New York, Appellate Division (December 20, 2000), reversed an order and judgment of the Supreme Court entered October, 14, 1999, in Broome County which granted a defendant's motion for summary judgment—dismissing claims of negligent treatment and lack of informed consent. The case arose out of a hernia repair surgery performed on the plaintiff after which he suffered a compromised blood flow to his right testicle, which ultimately had to be removed.

The Appellate Division cited the plaintiff's affidavit sufficient to defeat the motion for summary judgment with

respect to the claim of negligent treatment and on the cause of action for the lack of informed consent, the defendant did not establish a prima facie entitlement to summary judgment — the defendant offered no evidence that he advised the patient of the reasonably foreseeable risks associated with the surgical procedure, especially testicular damage. The Appellate Division ruled the defendant's proof relied on a signed surgical consent form which did not identify the nature of any risks disclosed and on the surgeon's deposition in which he only identified pain, swelling, and numbness as risks which could result from the surgery — each of which would abate over time.

Consent forms are considered valid until the patient either withdraws consent or the patient's medical condition, authorized treatment, or procedures change. How long a consent form is valid depends on state law or institutional bylaws, average is 30-days.

Accountability for Obtaining Informed Consent

Most state medical practice acts hold the medical healthcare provider, who is going to perform the treatment or procedure, as the responsible party for obtaining the patient's informed consent. It is legal for the physician to delegate to another healthcare provider (e.g. nurse) the responsibility of obtaining a patient's informed consent; any deficiencies in the informed consent obtained by the delegated healthcare provider may be imputed back to the responsible healthcare provider (*Grabowski v. Quigley*, 1996).

Generally, hospitals are not held liable for obtaining informed consent unless the healthcare provider performing the treatment or procedure is an employee of the hospital or the hospital knew of the lack of the informed consent and did not take action. Hospitals have begun to prohibit medical healthcare providers from delegating the accountability for obtaining a patient's informed consent to nurses because hospital liability is increased under the doctrine of respondent superior — once a nurse becomes an integral part of the informed consent process (Guido, 2001).

Healthcare Provider-Patient Discussion

"A meaningful discussion with the patient about proposed treatment presupposes that the patient comprehends his medical condition and its seriousness. Only then can the necessity for therapy or the prognosis of the illness without treatment be realistically discussed" (Mawn, 1999, p. 1). This communication dialogue assists the healthcare provider-patient relationship through developing the critical element of trust — this dialogue is often the most important discussion a healthcare provider will have with his or her patient (Yale New Haven Hospital Risk Management Handbook, 2002).

It is well documented in the literature that healthcare providers have a duty to make disclosures regarding proposed treatment or procedure to his or her patient prior to

undergoing proposed treatment or procedure and to provide this information in terminology that is comprehensible to the patient. Though these facts are well purported, healthcare providers continue to be named as defendants in medical malpractice cases alleging cause of action issues of negligence and/or lack of informed consent.

Braddock, Edwards, Hasanberg, et al. (1999) investigated informed decision-making practices by physicians in outpatient settings. Results indicated a total of 3,552 clinical decisions were made, yet only nine percent (9%) of all decisions met the criteria for completeness of informed decision-making. Elements of the informed decision-making process that were frequently omitted included "alternatives, pros and cons, and uncertainties" (Help Reduce the Incidence of Medical Malpractice Lawsuits, 2002, p.1).

A recent review of medical malpractice claims at a medical malpractice insurance company estimated that 30% of claims made for medical malpractice charged a lack of informed consent (Byington, 2000). Viable causes of action for lack of informed consent based upon a healthcare provider's (physician) failure to provide complete and accurate procedure information occurred in two recent medical malpractice cases: *King v. Jordan* (1999) and *Motichka v. Cody* (2001).

Patient attributes affecting communication dialogue were identified in the literature as physiological impairments (visual or hearing problems), language and cultural differences, as well as incompetency and illiteracy. These attributes may lead to a patient consenting to a treatment or procedure even though he or she lacks the level of comprehension to make an informed choice (Croke, 2002). Other communication issues include increased patient workload and shorter consultation periods — healthcare providers may not take the time to adequately educate their patients. A 1993 study by Physicians Insurers Association of America (1993) examined 393 drug-related malpractice claims and reported that 18% of the claims resulted from "communication failure between doctor and patient" (Help Reduce the Incidence of Medical Malpractice Lawsuits, 2002, p. 1).

Consent for a treatment or procedure can be evident by a signed and witnessed document. Informed consent can be evident by a note in the patient's medical record which details the content of the dialogue between the healthcare provider and patient or by the patient "willfully undergoing the procedure by appearing at the appointed time and place" (Springhouse, 2000, p. 86). Informed consent laws vary by state — a signed and witnessed consent form may be valid in one state, yet may be refutable in another if a patient offers sufficient evidence to the contrary (Springhouse).

Discussion

A medical malpractice case alleging a cause of action claim for lack of informed consent is usually a corollary with a negligence claim. In a claim for lack of informed consent, the plaintiff alleges that the healthcare provider failed to follow the standard of care for informed consent by not informing him or her (or the legal guardian) of the “reasonably foreseeable risks” of the treatment or procedure in question and that had the patient or legal guardian been “duly informed” of those risks, the patient would not have gone through with the treatment or procedure which purportedly caused the patient harm (Zwerling, 2003). Contemporaneous documentation of the elements of informed consent serve as the foundation for the defense of any subsequent claim by the patient or legal guardian for lack of informed consent (Yale New Haven Hospital Risk Management Handbook, 2002). Litigation has shown that *if it was not documented — it was not done*.

Role of the Legal Nurse Consultant

When asked to review a patient’s medical record to determine the merits of a lack of informed consent injury case, the legal nurse consultant (LNC) should review the state’s laws on informed consent; the institution’s informed consent policies, procedures, and specific condition protocols and any underlying patient physical attributes. These factors, when assessed and monitored appropriately by all healthcare professionals, may prevent the need for litigation.

To be effective in this role, the LNC needs knowledge of current informed consent standards and guidelines that will ensure a comprehensive evaluation. Guidelines for evaluating all essential materials, such as patient records, depositions, state laws, and the institutions policies, procedures, and protocols are found in **Table 1**. These guidelines should aid in the search and evaluation of medical records and other documents and in forming a plan of action. In summary, when engaged in a search for and evaluation of a patient’s medical documents, the LNC should know about:

- A. Cause of action information including the alleged information omitted during the informed consent process by the healthcare provider and the alleged harm caused to the patient by the lack of information;
- B. Legal information on informed consent including state laws, disclosure standards and hospital policies, procedures and protocols relative to informed consent;
- C. Informed consent documentation of the informed consent process including the consent form, healthcare provider, and legal consent authorization;
- D. Documentation of patient’s physical attributes including medical conditions, medication regime, lab values, baseline history and physical examination, including a cognitive assessment, physiologic impairments, illiteracy problems, and communication barriers.

Obtaining documented evidence in these areas enables the LNC to provide the attorney with a comprehensive and accurate assessment of the quality of medical and patient care and the information given to the patient and family by all involved healthcare professionals (Croke & Mayberry, 2001).

Conclusion

Informed consent is a process not just signing a consent form. Standards for informed consent are fluid and changing, especially in the realm for treating minors, blood transfusions, genetic testing, HIV testing and reporting, right to life issues, incompetency, and confidentiality issues. Documenting the steps of the informed consent process that were taken prior to the patient undergoing a treatment or procedure and the results of these steps will help establish that the healthcare provider practiced in a manner consistent with current standards of care. Proper documentation further reduces or may eliminate blame directed to a healthcare provider(s) should litigation occur. Documentation is a power tool which supports healthcare providers who follow the legal standards of care (Croke & Mayberry, 2001).

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Table 1. Guidelines for Evaluating Medical Record of a Lack of Informed Consent Injury

I. Cause of action information

- What is the information alleged by the plaintiff to have been omitted by the healthcare provider during their discussion of the proposed procedure(s)?
- What is the alleged injury(s) caused by the lack of informed consent?

II. Legal information of informed consent process

- What are the state laws on informed consent?
- What is the state disclosure law for informed consent?
- What are the institutional policies, procedures and protocols for obtaining informed consent? Always coincide policies, procedures and protocols enforce at the institution with the date of the alleged incident.

III. Informed consent process documentation

must include:

- Is there a consent form?
 - Is the consent form signed by the patient? If not, who signed the consent form and did this person have the legal right (authority) to consent for the patient?
 - What is the treatment or procedure written on the consent form? Is it the same treatment or procedure the patient authorized and underwent?
 - Who witnessed the patient's signature? Was the date and time included?
 - Is the consent form written in the language of the patient? If not, who interpreted the consent form and is the interpreter's signature noted on the consent form?
 - Are the elements of informed consent printed or written on the consent form?
 - Is the healthcare provider(s) named on the consent form the same provider who performed the treatment or procedure? Need to review operative procedure forms (or special procedure form), anesthesia notes, and medical progress notes to review names on documents as to who performed the treatment or procedure.
 - How far in advance was the consent signed, prior to or after the treatment or procedure? Check medical records for when (date and time) and where (medical floor or other location) the consent was obtained.
- **Is there healthcare provider documentation of the informed consent process?**
 - Is there informed consent documentation written on consent form, in medical progress notes, in nurses notes or elsewhere in the medical record on the information taught to client and how patient verification was understood? What is the information listed?

- Who obtained the patient's informed consent? Was it the health care provider who performed the treatment or procedure or was it delegated to another health care provider?
- Is there documentation in the medical record as to who may legally authorize consent for the patient, if there is a competency issue?

IV. Patient documentation of physical attributes

- *Medical Conditions* — That may impair judgment, such as hypoxia, infections, dementia, Alzheimer's disease, metabolic disorders, or strokes.
- *Medication Regime* — List out and evaluate. Examine type, dosage, age of patient, report of side effects, and polypharmacy (checking, if necessary, serum levels for drug toxicity). For elderly patients the "window between therapeutic and toxic levels is frequently narrow and even a small change in physiologic status can predispose them to toxicity" (Brenner & Duffy-Durnin, 1998, p. 18). Classes of drugs which may cause confusion include anticholinergics, antihistamines, tricyclic antidepressants, sedative-hypnotics, antipsychotics, benzodiazapins, histamine-blockers, and others (Croke & Mayberry, 2001, p. 8). Monitor time for when medications were administered prior to or after patient authorized consent.
- *Lab Values* — There may be causes for electrolyte imbalances affecting the patient's cognition. Check especially levels of sodium, potassium, calcium, magnesium, and lithium. Check arterial blood gases and other electrolyte levels (Croke and Mayberry)
- *Baseline History and Physical Examination* — Including a cognitive assessment (serves as a baseline for monitoring changes in patient's cognitive status and provides for a quicker intervention to correct abnormality (Croke & Mayberry)
- *Physiologic Impairments* — If the patient had physiologic impairments, such as any history of blindness, loss of hearing or other conditions, were sensory aids, such as glasses, large print, visual aides, or hearing aids utilized during patient care and during the informed consent process?
- *Illiteracy Problems* — Were there any problems with literacy levels noted by the patient or documented in the medical record, such as inability to read the consent form due to readability level of consent forms. Check patient's educational level.
- *Communication Barriers* — If there were any communication barriers (any history of aphasia, altered level of consciousness, language problems, cultural differences, or other conditions) were present, how were informed consent needs being met?



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LNC for the Defense in a Medical Malpractice Case

Marjorie Berg Pugatch, BS MA

KEY WORDS

Negligence, Informed Consent, Liability

Was there negligence in the medical care rendered after ERCP induced duodenal perforation? A medical malpractice case alleging a cause of action claim for lack of informed consent is usually a corollary with a negligence claim. In a claim for lack of informed consent, the plaintiff alleges that the healthcare provider failed to follow the standard of care for informed consent.

The Medical Care Rendered After ERCP Induced Duodenal Perforation Was There Negligence?

Jane Doe, a 58-year-old female, was admitted to the hospital for an elective laparoscopic cholecystectomy due to chronic cholecystitis (inflammation of gall bladder) and cholelithiasis (gallstones) on September 20, 2000. The procedure was uneventful and the plaintiff was discharged on September 21, 2000. Four days later, she presented to the emergency room complaining of sudden onset of epigastric pain and right upper quadrant tenderness. Other symptoms were shaking, chills, dark urine, and nausea. Mrs. Doe described the pain as being similar to a gallstone attack. The plaintiff was admitted to the hospital under the care of the general surgeon who had performed the cholecystectomy. The plaintiff was made nothing by mouth and a nasogastric tube was placed to low suction. IV fluids and antibiotics were started, and a work-up to ascertain the underlying cause of the symptoms was begun. The differential diagnoses were: retained stones, bile leak, and common bile duct injury or duct obstruction.

Past Medical History

Hiatal hernia, gastric reflux, diverticulitis x2, status post umbilical hernia repair and status post laparoscopic cholecystectomy. The plaintiff had no known allergies and neither smoked or drank alcohol.

Physical Examination in the Emergency Room

Negative except for epigastric and right upper quadrant pain with tenderness but no guarding or rebound.

Initial Diagnostics

An abdominal sonogram on the evening of admission and a hydroxy iminodiacetic acid (HIDA) scan the following morning were both negative effectively serving to rule out a bile leak or collection. Chest x-ray was negative. Electrocardiogram (EKG) showed normal sinus rhythm. Vital signs were stable.

Emergency Department Relevant Blood Work Results

Elevated liver function tests and elevated pancreatic enzymes were noted (see Table 1).

Hospital Course

By the morning after admission (September 26), Mrs. Doe was having less abdominal pain and less epigastric tenderness. However, liver function tests and pancreatic enzymes remained elevated. The most likely diagnosis being considered by the afternoon of September 26 was a stone (choledocholithiasis) which was preventing the flow of bile from the liver and/or pancreas into the duodenum. At that point in time, a consult was requested of a gastroenterologist to determine whether Endoscopic Retrograde Cholangiopancreatography (ERCP) should be the next step. The gastroenterologist agreed with the plan for ERCP and explained the risks of the procedure to Mrs. Doe. The procedure was scheduled for September 28. A consent for ERCP with general anesthesia was obtained. Because of the decrease of the abdominal pain after admission, it was thought that a stone may have passed on its own or was "ball-valving" thereby creating an intermittent obstruction. The plaintiff continued to be pain free on September 27.

Endoscopic Retrograde Cholangiopancreatography

On September 28 at 3:45 p.m., the plaintiff was taken to the procedure room. The duodenoscope was passed and several attempts to enter the duodenal papilla (mouth to the conjoined pancreatic/common bile duct) were made. Finally, the pancreatic duct was entered and appeared normal in size, shape and contour. A pancreatic stent (#5 F 5 cm.) was placed and a sphincterotomy was done. A gush of bile was noted which was followed by bleeding. The papilla became covered with blood and 15 c.c.s of 1:10,000 epinephrine was injected all around the entire area. The bleeding ceased. An attempt to enter the sphincterotomy with a catheter was made and dye was

injected which outlined the duodenum (duodenal perforation). The procedure was immediately stopped and an x-ray was obtained which revealed retroperitoneal air in the right upper quadrant and a small amount of free intraperitoneal air under the right hemidiaphragm.

The plaintiff was taken to the Perianesthesia Care Unit (PACU) at 6:30 p.m. A nasogastric tube was placed and returned blood tinged reddish-brown material. Antibiotics were re-instituted. The abdomen was firm with bowel sounds. The plaintiff was alert and oriented. Another abdominal film was repeated two hours later and was unchanged. Vital signs remained stable. The plaintiff complained of severe abdominal pain while in the PACU and was given Demerol three times (see Table 2). The plaintiff was transferred to the ICU for close observation.

Intensive Care Unit

The plaintiff arrived in the Intensive Care Unit at 9:15 p.m. Vital signs were essentially stable. Oxygen therapy was begun via nasal cannula. The abdomen was soft but tender with hypoactive bowel sounds. The plaintiff complained of increased abdominal pain upon transfer from gurney to bed and was medicated.

September 29

In the morning an abdominal x-ray was done and again showed a large amount of retroperitoneal air and evidence of a small amount of free intraperitoneal air. Various physicians evaluated the plaintiff's abdomen several times in the morning. There appeared to be little, if any,

improvement in the distension and tenderness aspects but there was also no guarding or rebound. **Analgesia was needed at regular intervals** (see Table 2). X-rays were done and compared with the previous films. Evidence of pneumo-retroperitoneum as well as a small quantity of free intraperitoneal air was found. Both findings appeared somewhat decreased from the prior film. A computerized tomography (CT) abdominal scan without IV contrast was done in the afternoon and revealed a large amount of retroperitoneal air extending into the mediastinum and a small amount of free fluid in the paracolic gutters. A small amount of oral contrast was given and was seen within the fundus of the stomach but never reached the duodenum, and therefore was **non-diagnostic in terms of evaluating the perforation.**

Another surgeon was brought in for a second opinion. He found the abdomen to be moderately distended and diffusely tender in the lower quadrants. He noted hypoactive bowel sounds. His impressions were that the plaintiff had a retroperitoneal duodenal/common bile duct perforation with pancreatitis secondarily. His recommendations were to continue conservative treatment over the next 12 to 24 hours and to do an exploratory laparotomy if there was no improvement or if the plaintiff's condition worsened.

In the evening, the plaintiff was again evaluated and complained of increased pain especially in the lower abdomen. Bowel sounds were rare, and the abdomen was distended and diffusely tender. At 7:00 p.m. the plaintiff was experiencing **back spasm** at the right flank which was thought to be related to a pre-existing back problem.

Table 1: Laboratory Data

Date	Amy-lase (53-123)	Lipase (.12-1.0)	T. Bili (0.2-1.0)	GGTP (1-94)	ALT (SGOT) (7-37)	AST (SGPT) (0-48)	Alk. Phos. (50-160)	LDH (79-179)	Ca (8.5-10.5)
9/25	97	0.6	1.2	238	452	261	243	471	9.5
9/26	146		2.7		1463	1142	294		
9/27	127	2.1	1.7	335	708	1048	415	551	8.8
9/28 Pre-ERCP	68								
Post ERCP	303		1.1		680		420		8.5
9/29 7:00 a.m.	378	6.2							8.0
9/29 6:00 p.m.	443								7.5
9/30 6:00 a.m.	469		1.2		153	81	233	200	6.2
9/30 6:00 p.m.	414								5.8

The spasms were treated with Valium. Her abdomen was firmly distended with faint hypoactive bowel sounds. Her urine output was tea colored and adequate in quantity but was markedly decreased from earlier quantities. The plaintiff was evaluated again at 10:00 p.m. by the surgeon. Four 500 cc normal saline boluses were given from 10:00 p.m. to 6:00 a.m. The fluid intake over the previous 24 hours was far exceeding output.

September 30

At 7:00 a.m. Jane Doe's abdomen remained firm, distended, diffusely tender without rebound or guarding. Urine remained tea colored. The white blood cell count was 13.9, amylase remained elevated, and calcium was decreased significantly. Both the gastroenterologist and the consulting surgeon indicated that the plaintiff was slowly improving with less abdominal pain and less distension than the previous evening. However, she continued to complain about back spasms.

At 2:30 p.m., the gastroenterologist again evaluated her. Amylase remained high, while liver chemistries decreased. The impression at that time was retroperitoneal perforation with slightly improved symptoms, ileus and pancreatitis. The plaintiff again needed IV boluses to increase the urine output. By 6:00 p.m. the plaintiff's abdomen remained distended and firm but less tender. The plaintiff was complaining of less pain. The urine output continued to decrease and become more concentrated. IV fluids were given to counteract the imbalance. The plaintiff started to run a fever in the evening.

October 1

Fluid balance, hypocalcemia, intermittent abdominal pain, distension and tenderness (without guarding or rebound), fever, increased heart rate, and decreased oxygen saturation were all noted to be problematic. The plaintiff was prepped with contrast via a nasogastric tube for the abdominal CT scan. At 10:30 a.m. she was transported to radiology. The plaintiff was noted to have an expiratory wheeze during the procedure. The oxygen saturation remained at 93%. **The CT scan revealed some extravasation of contrast in the retroperitoneum** and increasing retroperitoneal air. The unopacified pancreas was unchanged. There was no bowel obstruction.

The plaintiff was taken to surgery in the afternoon where an exploratory laparotomy was done to repair the retroperitoneal duodenal perforation found at the junction of the duodenum and pancreas. There was spillage of bile into the retroperitoneum. The surgery included a T-tube insertion into the duodenal perforation and closure around it, gastrojejunostomy and a duodenal exclusion. Because the bowel was distended the abdomen could not be closed and was therefore left open.

Shortly after surgery the plaintiff developed adult respiratory distress syndrome and her pulmonary condition further deteriorated, resulting in respiratory and cardiac failure. Death ensued the following day.

Role of the LNC

The LNC was asked to summarize the records as done above, to research the management of duodenal perforations and to analyze the care rendered based on the prevailing research.

Duodenal Perforations and ERCP

ERCP with sphincterotomy has a complication rate of approximately 10% and includes pancreatitis, infection, bleeding, and perforation of the duodenum. (Cotton et al., 1991) Perforations occur in about 1% of patients, and such an injury has a death rate of 16% to 18%. (Stapfer et al., 2000) A consensus, as to the care of the patient with a perforated duodenum during ERCP, is lacking. (Chung et al., 1993) Failed non-surgical management has carried a very high mortality rate, yet surgical exploration has its associated risks. The decision to medically manage versus surgically intervene seems to have "evolved toward a more selective approach." (Stapfer et al., 2000) The decision to take a patient to surgery or to wait is an on-going process of evaluation of the clinical features and radiological findings. In the case at hand, the perforation was a small retroperitoneal perforation caused by a guide-wire or catheter that was expected to seal itself. If the perforation were to seal, the clinical picture would find a patient with diminishing symptoms. However, this could only be ascertained from meticulous clinical evaluation coupled with imaging studies (UGI, double-contrast CT scan) to confirm that the leak sealed.

LNC Case Evaluation

There was no question that a duodenal perforation had occurred as reported by the gastroenterologist who performed ERCP. In addition, it was seen on contrast study at the close of the procedure. The series of abdominal x-rays reporting retroperitoneal air along with a small amount of free intraperitoneal air supported the existence of a perforation. The perforation was considered small because the equipment that caused the perforation was either a guidewire or catheter with measurements of 1.7 mm to 6 mm. Historically, many small retroperitoneal duodenal perforations caused by ERCP will spontaneously seal within the first 24 to 36 hours. (Stapfer et al., 2000) Therefore, case evaluation centered on whether the records would lead our defendant surgeons to conclude that the perforation had sealed. However, a confounding aspect to case evaluation and to medical evaluation was the possibility that pancreatitis, a not unexpected complication of ERCP, was responsible for the clinical symptoms. A table (see Table 1) of various chemistries revealed increased pancreatic enzyme production.

An evaluation of clinical status included the complaints offered by the plaintiff, plaintiff's physical examination, especially of the abdomen, and the level of analgesia required to diminish the plaintiff's pain. The abdominal examination revealed a tender, distended abdomen without guarding or rebound. These findings never seemed to improve to the extent that one would

expect if the perforation had sealed. In addition, an analgesia table showed that the level of pain never abated to the level of what would be expected if the perforation had sealed. However, the abdominal findings and complaints of pain could also be associated with pancreatitis. Lastly, imaging studies did not seem to show improvement.

Abdominal x-rays continued to show retroperitoneal air and free intraperitoneal air. The abdominal CT scan that was done the day after ERCP showed extensive retroperitoneal air and a small amount of free fluid but was **non-diagnostic in terms of evaluating for a perforation**. In addition, it showed a normal appearing pancreas. **The surgeons were not able to definitively make any conclusions as to the status of the perforation based on the scan, and no attempt to elicit the status of the perforation was made until two days later when an upper gastrointestinal abdominal CT scan showed extravasation.** These findings resulted in an emergency laparotomy on a patient who had deteriorated considerably after the first CT scan.

In conclusion, the weaknesses of the defense case were the level of pain, the continued abdominal complaints, the continued findings on abdominal examination, the existing imaging studies, and the **failure to obtain diagnostic studies to prove the leak had sealed**. The strengths of the defense case were the location of the perforation, which would lend itself to self-sealing; the small size of the perforation, as evidenced by the equipment used and the probability of pancreatitis as evidenced by the laboratory data which could account for the abdominal findings and complaints of abdominal pain.

Case Claims

Claims were made against the general surgeon and consulting surgeon. The jury was asked to answer the following questions. Did the surgeon and consulting surgeon depart from accepted medical practice in not operating on or before the morning of September 30? And, if so, was it a substantial factor in causing the plaintiff's death?

Plaintiff's Expert

The plaintiffs called an expert surgeon with experience in ERCP duodenal perforation who testified as to the care rendered by the defendant surgeons. He agreed that it was acceptable for the surgeons to allow a period of observation to see if the perforation had sealed itself before submitting the plaintiff to surgery. The plaintiff exhibited typical signs and symptoms during the first 24 hours associated with this type of injury. However, the surgeon indicated that he would expect improvement thereafter, and his review of the records did not support continued improvement. The plaintiff developed pain and tenderness in areas previously not complained of. She developed more abdominal distension. She also began to complain of back spasms which could be interpreted as consistent with increased retroperitoneal inflammation. The plaintiff's witness also indicated that the first CT scan revealed a normal pancreas.

If the plaintiff had anything but a mild case of pancreatitis, the CT scan would show some pancreatic enlargement or fluid. The expert opined that pancreatitis, if there was any, was caused by the exposure of the pancreas to the leaking digestive enzymes through the perforation and not from the pancreas itself. In addition, the CT scan showed

Table 2: Medication Data

Date	Time	Medication	Comments
9/28 Post ERCP	7:20 p.m.	Demerol 25 mg.	
	7:35 p.m.	Same	
	8:20 p.m.	Same	PACU
	8:45 p.m.	Same	
	9:30 p.m.	Demerol 75 mg. w/ Vistaril	ICU
9/29	12:50 a.m.	Same	
	4:00 a.m.	Same	
	11:00 a.m.	Codeine 30 mg.	
	2:15 p.m.	Valium 2 mg. IVP	Back spasms
	2:55 p.m.	Codeine 30 mg. IM	
	5:15 p.m.	Morphine 5 mg.	
	7:30 p.m.	Same	
	9:00 p.m.	Valium 2 mg. IVP	Back spasms
	10:30 p.m.	Morphine 5 mg.	
	9/30	2:30 a.m.	Same
9:30 a.m.		Same	
10:00 a.m.		Valium 2 mg. IV	Back spasms
11:30 a.m.		Morphine 5 mg.	
1:30 a.m.		Same	
8:00 p.m.		Same	
10:00 p.m.		Valium 2 mg. IV	Back spasms
10/1	12 midnight	Morphine 5 mg.	
	5 a.m.	Same	
	10:30 a.m.	Same	Post CT scan
	2:30 p.m.		To surgery

that retroperitoneal air had spread out from the initial perforation and some free fluid was now present. Clinically, after this CT scan, the plaintiff continued to develop new symptoms such as back pain and fluid sequestration that was evidence of an on-going progressive inflammatory process.

The plaintiff's expert disclosed that it was incumbent upon the surgeons to either do further diagnostics to prove the leak had sealed, and to do so promptly, or to take the plaintiff to surgery to perform an exploratory laparotomy to evaluate the duodenal perforation.

Waiting two days longer increased the inflammation, increased the pressure in the abdomen, increased fluid accumulation and caused additional tissue destruction.

Furthermore, it resulted in a more complex surgical procedure to close the perforation. Had surgery been performed earlier there would have been less inflammation and there would have been a greater likelihood that the perforation could have been closed with a few sutures. There would have been no need to exclude the duodenum or to do a gastrojejunostomy.

Defense Expert

A surgeon was called in as an expert witness for the defendants. His opinion was that the laboratory data (elevated lactate dehydrogenase, amylase, WBC, and decreased calcium), imaging studies and clinical symptoms pointed to an underlying pancreatitis which led to the development of a systemic inflammatory response syndrome (SIRS). In his view, SIRS was responsible for the hospital course that the plaintiff endured. He indicated that if pancreatitis were caused by digestive juices leaking onto the pancreas through a perforation, as asserted by the plaintiffs, the organ would have shown inflammation mainly on the organ's surface (peripancreatitis) which was not found at autopsy.

The microscopic examination of the pancreas showed signs of necrosis, hemorrhage, and inflammation all of which were consistent with a pancreatitis. Furthermore, the surgical report described the pancreas as appearing inflamed in its entirety. He also indicated that it was reasonable for the physicians to expect a small duodenal perforation to seal itself. He described the nature of the retroperitoneum as composed of tissues that adhere to one another creating a compressive force on any small perforation. The expert witness also believed that the type of surgery that was done on September 30 would not necessarily have been any different if the surgery was done a day or two earlier and such an assertion was speculative.

As to the first abdominal CAT scan showing a small amount of fluid, the surgeon believed this finding to be the body's reaction to pancreatitis and not leakage of fluid through the perforation. He concluded his testimony supporting the actions of the surgeons based on the presenting clinical, laboratory and imaging studies.

Jury's Decision

The jury took two and a half days to return a verdict. They decided that both physicians departed from accepted medical practice in not operating on or before September 30 and this departure was a substantial factor in the death of the plaintiff. The amount awarded for pain and suffering, past economic loss, and future economic loss amounted to slightly less than a \$2,000,000 verdict.

LNC Conclusions

The role of the LNC was, first, to summarize the records. Next, the LNC gathered research on ERCP including the complications thereof and the treatment options and analyzed the records in comparison to the research. The LNC then pointed out the strengths and weaknesses of the care rendered to the plaintiff by the defendant surgeons in comparison to the prevailing research on how to handle duodenal perforations. It was clear from the research obtained, that even if surgical intervention occurred prior to September 30, the end result to the plaintiff might, very well, have been the same because of the pancreatitis. However, the conclusions that could be drawn from scrutinizing the care rendered to the plaintiff, was that the physicians waited too long and did not obtain enough diagnostic information to warrant their continued waiting.

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Book Review

Nurse's Legal Handbook

Marcia Andrews, Kathy Goldberg, Howard Kaplan, and Michael Shaw

Springhouse Publishing

Reviewed by Kara DiCecco, R.N

As any legal nurse consultant can tell you, building a personal reference library is fundamental for a successful consulting practice. Despite the rapid advances in technology and the ease of Internet access, the reference book remains the cornerstone of the LNC's library. It is the authority that you repeatedly turn to during initial case development through the concluding stages of litigation.

There are four elements of a quality reference book. They are: 1) reliability, 2) authority, 3) comprehension, and 4) affordability. Too often the LNC consumer sacrifices affordability in favor of the first three essential elements. *The Nurse's Legal Handbook* by Springhouse Publishing easily captures all the elements, including the elusive fourth.

The authors have assembled an impressive breadth of legal information and distilled its basic parts into a readable format. Whether the reader is a novice or veteran LNC, the information is clear, concise and pertinent. For the more advanced LNC, the authors have included a magnitude of legal information and resources in this concise reference.

The 11 chapters cover geographically diverse case law to illustrate how state laws can vary and impact nursing

practice. The book avoids overstated legal analysis and verbal elitism. Instead, the book concisely and accurately examines legal principles and professional standards for a more complete understanding. The reference provides examples of previously adjudicated issues and explains the implications of the legal precedent set by the court's holdings. The book addresses a wide range of topics including patient's rights, nurse's responsibilities on and off the job, reflections on bioethics, and multi-dimensional concerns of medical malpractice.

Certainly any practicing nurse with an interest in learning more about legal responsibilities and rights will benefit from this book that includes numerous areas of practice. Maybe the worst that can be said about the handbook is that it may have missed targeting a more focused audience. This book is an invaluable resource for locating scope of practice guidelines, applicable case law, and close examination of legal findings. The handbook is not only versatile, it is reliable, authoritative, comprehensive, and yes, affordable. Pages: 422, Cost: \$36.95.

Feminist Perspectives on Advocacy: Implications for Legal Nurse Consulting

Regina Noonan, RN MSN LNCC

KEY WORDS

Advocacy, Feminism, Philosophy

The purpose of this article is to examine attributes of advocacy that are feminist, examine these attributes with implications for legal nurse consultants (LNCs), propose a feminist perspective as a philosophical basis for practicing legal nurse consulting, and introduce the partnership model of advocacy as a practice model for LNCs.

Legal nurse consultants (LNCs) have been heard to say “when I left nursing...,” or “the medical record is my patient,” and on legal nurse consulting listservs have been noted to ask “how do I do...” It is less frequent that LNCs discuss “why am I doing what I do?” and “what am I really doing?” Discussions are usually of a functional orientation. This is understandable as much of LNCs’ evaluative feedback is based on work products — tangible outcomes of their tasks. Legal nurse consulting is a fairly new profession and we are all anxious about proving our worth. As we are becoming an established and respected profession, these anxieties are subsiding. Tenured LNCs are contemplating “What am I really doing?” and “Am I still a nurse?” They have been heard to complain that they are “tired of just reviewing medical records” and look to “feel good” about what they do, as they did in clinical nursing. These comments reflect LNC burnout. Yes, believe it or not in a profession as young as ours, there is already burnout. The burnout comes with the task orientation of the job, and practicing without a theoretical and philosophical framework.

LNCs that practice within a philosophical feminist framework of advocacy, that embraces caring, connection, subjectivity, and diversity, and is relational, are less likely to experience the burnout. A philosophical focus enables one to feel connected to their profession and good about the tasks that they do. The functional orientation becomes meaningful. Philosophical perspectives are similar to theoretical perspectives. Theoretical perspectives provide guidance and direction to thought, and philosophical perspectives add valuation to practice. Both give more meaning to what it is that LNCs are doing; a valuation perspective that embraces nurse caring and connection, and cross-jurisdictional advocacy (Noonan, 1998, 2000, 2003).

The purpose of this article is to examine attributes of advocacy that are feminist, examine these attributes with implications for LNCs, propose a feminist perspective as a philosophical basis for practicing legal nurse consulting, and introduce the partnership model of advocacy as a practice model for LNCs.

Definition of Terms

Feminism, as defined for this paper, represents a worldview, not just issues related to gender injustice. Feminism is a paradigm that rejects dichotomies and exclusive categories, that values personal human relationships, embraces caring, connection, holism, the lived experience, respect, peace, client-centeredness, engagement with individuals, morality, and social responsibility, and opposes hierarchical relationships (paternalism), and exploitation of individuals (Gaut, 1991; Macpherson, 1991).

Paternalism is defined as “the principle or practice on the part of...any person in authority, of managing or regulating the affairs of...individuals...” (Barnhart, 1966). The more common usage of the term paternalism, in the health care environment, being “doctor knows best” (Jones, 1996). Paternalism has also been defined as the “use of force or coercion to accomplish a measure with which the patient is known to disagree, those decisions concerning a [client] made without ascertaining and respecting the individual’s wishes,....the violations of [client’s] freedom of self determination”....and those practices in which there is conflict “between the individual’s own view of his or her best interest and the professional’s view of the [client’s] best interest” (Gadow, 1983). Jones (1996) distinguished between traditional and modern day paternalism; the traditional model being that in which the health care provider is in control of all health care decisions and that of the modern model in which the health care provider considers the client’s views and values yet still makes the final decision.

Autonomy is a term derived from the Greek with the root words — auto (self) and nomos (rule, governance, or law) — meaning self governance (Beauchamp & Childress, 1983) and self-law (Katz, 1984). Self-determination is synonymous with an individual’s autonomy (Beauchamp & Childress, 1983).

An advocate is “one that pleads the cause of another, defender, one that argues for, defends, maintains, or recommends a cause or proposal” (Gove, 1976); a pleader for the vulnerable (Copp, 1986). Advocacy is “to speak, plead or argue in favor of, a supporter, a defender, one that pleads on

behalf of another, an intercessor, a lawyer" (American Heritage). Advocacy has historical significance to nursing; a "viable construct underlying the very foundation of nursing" (Donahue, 1985) and a role of nursing that can be traced to Florence Nightingale (Bramlett, Gueldner & Sowell, 1990). Advocacy is a nursing value, a moral principle, and an ethic of the profession. Nurse advocacy has been compared to lawyer advocacy wherein both plead and present their client's case regardless of personal or societal judgments, accepting the inherent adversarial nature of the role (Sanchez-Sweatman, 1999).

Review of the Literature

Autonomy, Self-Determination, Paternalism, and Advocacy

Komrad, as cited in Jones (1996), noted that autonomy and paternalism were "two inversely varying parameters along a spectrum of independence." Katz (1984) also viewed self-determination and paternalism on a continuum with paternalism being the total surrender of decision making to another and self-determination the "rights of individuals to make decisions without interference by others." Gadow (1983) felt the paternalism became more of an issue, not when patients [clients] relinquished their autonomy to professionals, but when it was not recoverable.

Ethics

Beauchamp and Childress (1983) felt paternalism had roots in the ethical principles of nonmalificence — the prevention of or to do no harm, and beneficence — the balancing of goods against possible harm. The paternalism occurred when the health care professional's conception of benefit and harm differed from that of the patient, and decisions affecting the patient were made by the health care professional. Beauchamp and Childress differentiated between weak paternalism — advocating when an individual had diminished capacity, and strong paternalism — limiting choices and liberty even when an individual's choices were informed and voluntary. Beauchamp and Childress concluded that ethically it was difficult to justify strong paternalism; however, felt weak paternalism was defensible as weak paternalism was not a violation of autonomy.

Gadow (1983) felt that advocacy was derived from ethical principles of autonomy and self-determination, which conflicted with the principles underlying paternalism. Gadow viewed advocacy as a partnership and developed an advocacy model with the partnership between patients [clients] and professionals "based upon the freedom of individual self-determination as the highest value in the patient-professional relationship." Gadow felt that this advocacy model was different from paternalism in which the professional was the decision maker. The advocacy partnership was one in which the professional participated with the client to enhance self-determination in decision making. The professional was viewed as the patient's [client's] assistant who assisted in discerning and clarifying health care information

and patient's beliefs, values and goals. Gadow (1992) referred to this as existential advocacy.

Best Interests

Gadow (1983) defined "best interest" as that which was in the patients' [clients'] "self interest" as decided on by the patient [client]. Rose (1995) defined advocacy as a mixture of promoting autonomy and best interest; acting on behalf of those unable to do so for themselves. Rose felt that best interest did not conflict with autonomy as competence was a prerequisite of autonomy and incompetence a defining attribute of best interest. Rose felt that advocating for clients' best interests included empowering and encouraging clients to participate — attributes of partnering with clients.

Feminism and Nurse Advocacy

Advocating for client self-determination, client empowerment and in client's self-defined best interest would be consistent with feminist perspectives on advocacy. Nursing advocates are professionals who facilitate client autonomy and self-determination in decision making through empowerment and advocacy, and in situations of diminished autonomy, assume the role of advocate in best interests of their clients. The nurse advocate's goal is to return the client to a state of autonomous decision-making. This would be consistent with Orem's (1991) theory of self-care and Lamb's (1994) model of partnership....goals which are consistent with feminist perspectives on advocacy.

Feminist jurisprudence is a philosophy and epistemology of law that maintains that society and the legal system are patriarchal. The initial movement emerged from early feminist litigator's reactions to gendered legal issues such as employment discrimination, domestic violence, and reproductive issues, and evolved into a school of thought challenging, not only gendered issues, but the actual epistemological and philosophical practice of law. Feminist scholars maintained that the laws were abstract, universal, dualistic, and objective, and acted only on a "frozen slice of reality" within a "rights" framework (Gilligan, 1993; Scales, 1986; Scoular, 1993). In this type of legal system, gender, real human predicaments, subjectivity, personal narratives, multiplicities of truths, and cultural diversity were not represented. Feminist jurisprudence has philosophical principles consistent with nursing positions on truth and nursing inquiry (Kikuchi, Simmons, & Romyn, 1996) and postmodern feminism (Tong, 1998). Feminism, nursing, and feminist jurisprudence value caring, connection, self-determination, person-oriented truths, and professional partnerships. These values support feministic strategies of advocacy.

Implications for Legal Nurse Consulting

For litigant clients there may be mental health consequences of litigation. Strasburger (1999) described the legal system as adversarial and traumatic, comparing the judicial process to combat and casualties. The discovery process, depositions, and direct and cross-examinations were described as violating privacy, and exacerbating stress,

vulnerability, and victimization. The stress was described as similar to a posttraumatic stress disorder, effecting both plaintiffs and defendants, irrespective of who won a case, and causing symptoms of sleeplessness, anger, frustration, humiliation, headaches, difficulty concentrating, loss of self-confidence, indecision, anxiety, and despondency. These symptoms were not only a result of litigants reliving the original trauma, but secondary to issues of power and control in the attorney-client relationship in the same way paternalism occurred in health care relationships.

By recognizing mental health consequences of litigation, and re-victimization by paternalism and disempowerment, LNCs with philosophical foundations rooted in feminism, are in a position to be effective advocates for their clients. LNCs that practice beyond a functional orientation can provide caring and connection through cross-jurisdictional advocacy (Noonan, 2000). LNCs can intervene in conflict situations, empower clients by increasing autonomous decision-making, and advocate for clients best interests by increasing competency through education and communication. This model of legal nurse consulting practice may seem more suitable for the plaintiff LNC; however, is also appropriate for defendant and independent LNCs.

All LNCs increase competency through education and communication, simply by deciphering medical records and more complexly by proposing litigation strategies and alternative causation. As such, defendant healthcare providers and product manufacturers are in a better position to have their positions heard. When medical records are transcribed, the records speak to the truth of events. LNCs can transfer this knowledge to their client attorneys. As the two become able to share the same language and truth, they can partner together to form litigation strategies. The truth needs to be confronted at the onset of litigation. Effective advocacy depends on truth and communication. The LNC can function as the go-between in paternalistic attorney-client relationships.

LNCs are also in a position to advocate for clients when they prepare them to be effective witnesses on their own behalf. Frequently the facts of the case speak to a truth, and yet the threat of losing the case is real because the witness is unable to speak the truth to the jury. Working within a feminist philosophy, the LNC can help the client witness find their own voice and be effective advocates on their own behalf. This involves coaching them to a respected level of self-esteem, and working with them on their verbal and non-verbal patterns of communications.

LNCs are encouraged to borrow partnership models of advocacy from the nurse case management literature (Lamb & Stempel, 1994; Newell, 1996; Newman, 1996; Noonan, 1997; Stempel, Carlson & Michaels, 1996). In partnership models, the nurse case manager empowers clients to recognize themselves as self-care experts and facilitates development of self-care abilities. This is done by collaboratively implementing action plans. These strategies are effective in

the litigation process as clients who are self-care experts are confident in their abilities to represent themselves in depositions and at trial as their own witnesses.

Case managers Lamb and Stempel (1994) utilize the "growing as insider-expert model." The model recognizes the client as the expert and the nurse as the professional who facilitates that recognition. In legal nurse consulting, the client should be viewed as the expert as they are the individual to which the negligent malpractice, personal injury, or crime has occurred or been alleged. The legal nurse consultant enhances the client's recognition of their own expert status. This is not to be confused with actual professional experts who take the stand on behalf of their attorney clients. The legal nurse consulting relationship is usually between the LNC and the attorney. In this respect, the LNC advocates for the attorney's client through and with the attorney.

The LNC facilitates feminist advocacy, partnerships, and "growing as insider-expert" by enhancing attorneys' communications with clients, and thus having clients actively involved in decisions in the litigation process. Goals could be planned and pursued based on clients' self-defined best interests (i.e., settlement, mediation, trial). Mental health consequences of litigation could be minimized. LNCs could act as cross-jurisdictional advocates — intervening in conflict situations, facilitating readiness in the litigation process, minimizing stress, and trauma, acting as the go-between, disabling paternalistic attorney-client relationships, enabling clients to be autonomous in best interest decision-making throughout the discovery process, providing competency education to increase legal and health care knowledge, and empowering clients to be effective witnesses on their own behalf.

Conclusions

In order to be effective client advocates, LNCs have to clarify their values on autonomy, paternalism, and client empowerment, ask themselves whose best interest are they advocating for, and re-examine their professional ethical principles and feminist values. Feminist values extend beyond gendered issues, and are congruent with nursing views. Feminism and nursing both embrace caring, connection, peace, respect, honesty, equality, dignity, subjectivity, being present in relationships, stepping out of one's personal frame of reference, experiencing others, and being receptive to other's needs (Gaut, 1991; Macpherson, 1991). Freidan (1981) referred to this as human wholeness, a movement from feminism to humanism.

As feminism, feminist jurisprudence and nursing embrace similar values, LNCs are in a position to facilitate humanistic advocacy for all clients. LNCs can make a difference in both the legal and health care systems by working from a feminist philosophical perspective within a conceptual framework of cross-jurisdictional advocacy and a partnership model of practice. Practicing within these frameworks enables LNCs to remain focused on caring and connection, and not just functional tasks. Legal nurse

consultants were nurses before they were legal nurse consultants, and clients were never just their medical records.

It can be more challenging for defendant and independent LNCs, and LNCs working with national counsel in multidistrict product liability defense positions, as you may not have direct interaction with the client. In these cases the LNC must operate from the ethical position as truth-teller and the cross jurisdictional advocacy position of educator, communicator and networker. Some clients may not wish the truth to be told. LNCs need to tell the truth. The truth is an effective resource as case limitations can be dealt with. The litigation strategy may become to mitigate damages, or settle early. LNCs will be more effective when they work within a framework of feminism, as they will be true to their clients and true to themselves. We all need to work within philosophical frameworks and feel good about what it is we do. Even more so for the LNC as we chose nursing as a profession, and yet moved into a nursing role that at times seems more adversarial than caring.

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Nurse's Legal Handbook, Kara DiCecco, R.N.; 4:16 (BR)

Your Career in Nursing: Manage Your Future in the Changing World of Healthcare, Annette T. Vallano, MS RN CS; 3:20 (BR)

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Navigating Ophthalmology Records, Norman L. Edelstein, MD; 3:8

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Pediatrics

Considerations of Psychiatric Case Reviews, Rachel Happel, BSN RN; 2:3

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Peer Review

Defending the Negligent Credentialing Claim, Paul K. Reese, Esquire, and Karen J. Huff, BSN RN LNCC; 3:3

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PRK

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Rehabilitation

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Safety

Office-based Surgical Facilities: Safe or Unsafe?, Greater Detroit Chapter, Susan Hawkins, BS RN; 2:20 (Q&A)

Sentinel Events

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Standards of Consent

Liability Issues of Informed Consent: Healthcare Provider-Patient Relationship, Eileen Croke, EDD, MSN, RN, ANP; 4:3

Subluxation

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Surgical Facilities

Office-based Surgical Facilities: Safe or Unsafe?, Greater Detroit Chapter, Susan Hawkins, BS RN; 2:20 (Q&A)

Terminology

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Vision

An Eye For An Eye: How American Juries Evaluate Vision Loss Cases, Terry C. Cavanaugh, Esquire; 3:10

Navigating Ophthalmology Records, Norman L. Edelstein, MD; 3:8

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